Michael R. Warner, M.D.
Laser and Cosmetic Dermatology
Mohs Micrographic Surgery

THE COSMETIC & SKIN SURGERY CENTER

Wyatt C. To, M.D.
Facial Plastic and Reconstructive Surgery

PATIENT DEMOGRAPHIC SHEET

Name: ______________________________ Date: ______________

Occupation: ______________________________

Gender: ______________ Marital Status: ______________

Date of Birth: ______________ SSN: ______________

HOME:

Street: ______________________________

City: ______________ State: ______ Zip: ______________

Phone: ______________ Cell: ______________

E-Mail Address______________________________

Never miss a thing! ❐ Yes! I want to receive monthly newsletters with special promotions & perks!

How would you prefer to be contacted? ______________________________

WORK / SCHOOL:

Street: ______________________________

City: ______________ State: ______Zip: ______________

Phone: ______________ Fax: ______________

Please list family members or other persons, whom we may inform about your treatment, scheduling, and billing information.

Name	Relationship	Date of Birth	Phone#	Emergency Contact?
				❐ Yes ❐ No
				❐ Yes ❐ No
				❐ Yes ❐ No

How did you hear about The Cosmetic and Skin Surgery Center?

____

May we send a thank you note to the person who referred you (if applicable)? ☐ Yes ☐ No

PRACTICE FINANCIAL POLICY

- Full payment is due at the time of service.
- Cosmetic consult fees are nonrefundable and must be applied to in-office treatments within 6 months of consultation. **Fees may not be applied to product purchases.*
- Prepaid packages are final, nonrefundable and nontransferable; *and must be used within 12 months from date of prepayment*.
- Prepaid packages for services requiring sun avoidance *must be used within 12 months of first treatment*; and *first treatment must be utilized within 6 months of prepayment*.

Patient Signature: ______________________________ Date: ______________

THE COSMETIC AND SKIN SURGERY CENTER
SURGERY INFORMATION SHEET

Name: ______________________ Date: ______________

What area(s) are you interested in having improved? Please describe past treatments to this area.
____
____
What do you use on your skin in the morning? ______________________
What do you use on your skin in the evening? ______________________
Have you ever had or used the following?

Permanent makeup	☐ Yes	☐ No
Injected fillers (e.g. Juvéderm, Restylane, collagen)	☐ Yes	☐ No
Neurotoxins (e.g. Botox, Dysport, Xeomin)	☐ Yes	☐ No
Accutane	☐ Yes	☐ No

MEDICATION & ALLERGIES
(Please use the Medication Reconciliation Record)

Are you taking aspirin or medication containing aspirin?	☐ Yes	☐ No
Are you taking other NSAIDs (e.g. Advil, Aleve, etc.)	☐ Yes	☐ No
Have you taken any steroid preparations in the past year?	☐ Yes	☐ No
Do you take prophylactic antibiotics prior to procedures?	☐ Yes	☐ No

If yes, please state reason. ______________________

MEDICAL EVALUATION
How is your general health? ______________________
Are you presently being treated for any medical conditions? ______________________
____
When was your last physical examination? ______________________
Do you have any of the following?

Visual loss (one or both eyes)	☐ Yes	☐ No
"Dry" eyes	☐ Yes	☐ No
Itching or irritation of eyes	☐ Yes	☐ No
Blurred or double vision	☐ Yes	☐ No
Crossed or lazy eyes	☐ Yes	☐ No
Cornea problems	☐ Yes	☐ No
Thyroid eye disease	☐ Yes	☐ No
Wear glasses or contacts	☐ Yes	☐ No
Previous eye or eyelid surgery (if yes what type)	☐ Yes	☐ No

____

Difficulty breathing through nose	☐ Yes	☐ No
Previous injury to nose	☐ Yes	☐ No
Nasal allergies	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Sinus conditions	☐ Yes	☐ No
Previous nasal or sinus surgery (if yes what type)	☐ Yes	☐ No

____

Previous face or neck surgery (if yes what type)	☐ Yes	☐ No

____

Radiation to the face or neck	☐ Yes	☐ No

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Facial paralysis or weakness	☐ Yes	☐ No
Facial implants	☐ Yes	☐ No
Coronary or heart attack	☐ Yes	☐ No
Congenital heart disease	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Palpitations, irregular heartbeat or pacemaker/defibrillator	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Seizure Disorders	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Chronic lung disease	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Have you received psychiatric treatment?	☐ Yes	☐ No
If yes, were you hospitalized?	☐ Yes	☐ No
Has there been any recent crisis in your life?	☐ Yes	☐ No
Have you ever been treated for drug or alcohol dependency?	☐ Yes	☐ No
Liver disorders including hepatitis or cirrhosis	☐ Yes	☐ No
Kidney or bladder disorders or chronic infections	☐ Yes	☐ No
Spinal or back disorders	☐ Yes	☐ No
Previous blood clots or thrombophlebitis	☐ Yes	☐ No
Any bleeding disorders in self or family	☐ Yes	☐ No
Blood transfusions	☐ Yes	☐ No
Do you feel that for any reason you may be at risk for AIDS?	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Autoimmune diseases (e.g. lupus, rheumatoid arthritis)	☐ Yes	☐ No
Any unusual scarring or keloid formation	☐ Yes	☐ No
If applicable, are you pregnant or trying to get pregnant?	☐ Yes	☐ No
Skin cancer	☐ Yes	☐ No
Cold Sores	☐ Yes	☐ No
Do you smoke? (If yes please list packs per day and years)	☐ Yes	☐ No

____

Do you use an electronic cigarette or vape?	☐ Yes	☐ No
Do you use nicotine in any form? (e.g. patches, gum, etc.)	☐ Yes	☐ No
Do you drink more than two drinks per day?	☐ Yes	☐ No

Have you had a communicable disease in the past six months? ☐Y ☐N

If yes, please explain: ____

____

The information above is true and accurate to the best of my knowledge. ______________________
Patient Signature

Primary Care Physician:______________________ Phone Number:______________________

Please list below any questions you would like to have specifically answered during your consultation.

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DOB ______________ Patient Name ______________________________

Please list ALL known prescriptions, over- the-counter, herbals, and vitamin/mineral/dietary (nutritional) supplements.

Name (Reported by Patient)	**Dosage**	**Frequency**	**Route** (Oral, Sub-Q)

Are you ALLERGIC to any drugs or materials? ❒ YES ❒ NO If yes, list:

Allergy or Sensitivity (Reported by patient)	**Reaction**

LATEX ALLERGY ❒ YES ❒ NO **Patient Initials _______ Staff Initials _______**

(Physicians Initials) (Patient Signature) (Date)

63 Thomas Johnson Drive, Suite B | Frederick, MD 21702 | Phone: 301-698-2424 | Fax: 301-698-1018 | Web: www.frederickcosmeticsurgery.com

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**My signature confirms that I have reviewed the original list of prescriptions/medications.
I have marked and dated all changes, and to the best of my knowledge, is up-to-date and inclusive.**

Date	Patient/Guardian Signature	Physicians Initials

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